

AMENDED IN ASSEMBLY APRIL 10, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1921

Introduced by Assembly Member Hill

February 22, 2012

An act to add and repeal Article 4.4 (commencing with Section 1366.10) of Chapter 2.2 of Division 2 of the Health and Safety Code, and to add and repeal Chapter 8.3 (commencing with Section 10760) of Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1921, as amended, Hill. Health insurance: transitional reinsurance program.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of provisions governing health care service plans is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing federal law, the Patient Protection and Affordable Care Act, provides for implementation of certain reforms relative to health care coverage.

This bill, until January 1, 2018, would establish a transitional reinsurance program for health plans, and require participation by health care service plans and health insurers. The bill would require the Insurance Commissioner to select a reinsurance entity, which would collect payments from contributing health plans *and the United States Department of Health and Human Services on behalf of self-insured group plans* and pay claims, as specified. The bill would authorize the commissioner and the Director of Managed Health Care to take various

actions to implement the program. The bill would require contributing entities to make payments to the reinsurance entity no earlier than October 1, 2013, and would provide for the reinsurance entity to pay claims to a reinsurance-eligible recipient no earlier than January 1, 2014, with payments and claims to cease on December 31, 2016, except for necessary adjustments. Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Article 4.4 (commencing with Section 1366.10)
2 is added to Chapter 2.2 of Division 2 of the Health and Safety
3 Code, to read:

4
5 Article 4.4. Reinsurance
6

7 1366.10. For purposes of this article, the following terms have
8 the following meanings:

9 (a) "Applicable reinsurance entity" means a nonprofit entity
10 that carries out the duties as described in Section 10760.5 of the
11 Insurance Code.

12 (b) "Attachment point" means the threshold dollar amount of
13 costs incurred by a contributing entity for payment of ~~essential~~
14 health benefits; provided to an enrolled individual, after which
15 threshold the costs for ~~covered essential~~ health benefits are eligible
16 for reinsurance payments.

17 (c) "Benefit year" means a calendar year for which a health plan
18 provides coverage for health benefits.

19 (d) "California-specific reinsurance benefit and payment
20 parameters" means any notice issued by the director describing
21 procedures for collecting funds from contributing entities and
22 making payments to reinsurance-eligible recipients.

1 (e) “Coinsurance rate” means the rate at which the applicable
2 reinsurance entity will reimburse the reinsurance-eligible recipient
3 for costs incurred to cover essential health benefits, upon reaching
4 the attachment point and before reaching the reinsurance rate.
5 Coinsurance rate may be further defined by any federal or
6 California-specific benefits and payment parameters or regulation.

7 (f) “Contributing entity” means the following: an entity licensed
8 as a health care service plan by the department; ~~or in the case of~~
9 ~~a self-insured group health plan covering residents of California;~~
10 ~~the third-party administrator of the group health plan~~ *however, no*
11 *contributing entity shall have to make contributions on behalf of*
12 *plans that consists solely of excepted benefits, as defined in the*
13 *federal Public Health Service Act (42 U.S.C. Sec. 300gg-91(c)).*

14 (g) “Covered individual claim” means a properly documented
15 claim submitted by a reinsurance-eligible recipient for a reinsurance
16 payment from the transitional reinsurance program.

17 (h) “Federal reinsurance benefits and payment parameters”
18 means a notice issued by the Secretary of the United States
19 Department of Health and Human Services describing procedures
20 for collecting funds from contributing entities and making
21 payments to eligible reinsurance recipients.

22 (i) “Grandfathered health plan” shall have the meaning set forth
23 in Section 1251 of the PPACA.

24 (j) “PPACA” means the federal Patient Protection and
25 Affordable Care Act (Public Law 111-148), as amended by the
26 Health Care and Education Reconciliation Act of 2010 (Public
27 Law 111-152), and any subsequent rules or regulations issued
28 pursuant to that law.

29 (k) “Reinsurance cap” means the threshold dollar amount for
30 costs incurred by a reinsurance-eligible recipient for payment of
31 California essential health benefits for an enrolled individual, after
32 which threshold the costs for covered essential benefits are no
33 longer eligible for reinsurance payments. Reinsurance cap may be
34 further defined by any federal or California-specific benefits and
35 payment parameters or regulation.

36 (l) “Reinsurance contribution payment” means the required
37 payment by any contributing entity to the applicable reinsurance
38 entity, as further defined by regulation.

1 (m) “Reinsurance contribution year” means the 12-month period
2 for purposes of assessing contribution payments from contributing
3 entities, as further defined by regulation.

4 (n) “Reinsurance-eligible recipient” means, for purposes of the
5 transitional reinsurance program, the issuer of any health plan *or*
6 *health insurance coverage* offered in the California individual
7 market that is not a grandfathered plan.

8 (o) “State high-risk pool” means health insurance programs for
9 Californians unable to obtain coverage in the individual health
10 insurance market because of their preexisting conditions. State
11 high-risk pool specifically refers to either or both the California
12 Pre-Existing Condition Insurance Plan (PCIP) and the Managed
13 Risk Medical Insurance Program (MRMIP) both operated by the
14 Managed Risk Medical Insurance Board.

15 (p) “Third-party administrator” means the claims-processing
16 entity for a self-insurer. In the case of a self-insurer that processes
17 its own claims, the self-insurer itself will be considered the
18 third-party administrator for the purpose of the transitional
19 reinsurance program.

20 1366.11. The director and the Insurance Commissioner may
21 jointly modify the federal reinsurance benefits and payment
22 parameters by issuing a California-specific notice of benefits and
23 payment parameters by March ~~15~~ 1 of the year prior to the benefit
24 year.

25 The notice shall contain at least both of the following:

26 (a) The data requirements and data collection frequency for
27 reinsurance-eligible recipients.

28 (b) The reinsurance attachment point, reinsurance cap, and
29 coinsurance rate, if different from the corresponding parameters
30 specified in the federal notice of benefit and payment parameters.

31 The director’s notice shall not be subject to the Administrative
32 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
33 Part 1 of Division 3 of Title 2 of the Government Code).

34 1366.12. (a) A contributing entity that is licensed by the
35 department shall be required to do all of the following:

36 (1) Make payments to the applicable reinsurance entity
37 according to the procedures established by the PPACA or state
38 regulations.

1 (2) Comply with all reasonable requests of the applicable
2 reinsurance entity or the director for appropriate documentation
3 to establish earned premium for the reinsurance contribution period.

4 (3) Comply with any additional requirements as established by
5 state or federal regulations.

6 (b) A reinsurance-eligible recipient that is licensed by the
7 department shall do all of the following:

8 (1) Submit documentation on covered individual claims to the
9 applicable reinsurance entity in a format as established by any
10 federal benefit or payment parameters or any California-specific
11 benefit and payments parameters.

12 (2) Remit to the applicable reinsurance entity any payments of
13 reinsurance benefits deemed to be overpayments following an
14 audit or reconciliation of collections and payments.

15 (3) Comply with any additional requirements as established by
16 the PPACA, state regulations or any California-specific reinsurance
17 benefit and payment parameters.

18 1366.13. The director may issue orders to a contributing entity
19 licensed by the department whenever the director determines that
20 it is reasonably necessary to ensure compliance with Section
21 1366.12. A licensee to which an order pursuant to this section is
22 issued may, within 15 days of receipt of that order, request a
23 hearing at which the licensee may challenge the order.

24 1366.14. (a) This article shall be effective on January 1, 2013,
25 for purposes of selecting an applicable reinsurance entity and
26 adopting regulations, including emergency regulations to
27 implement the transitional reinsurance program; however, no
28 contributing entity shall be required to remit any payment to the
29 applicable reinsurance entity before October 1, 2013, and no
30 payment to a reinsurance-eligible recipient shall occur before
31 January 1, 2014.

32 (b) The applicable reinsurance entity shall cease requiring
33 collections from contributing entities and making payments to
34 reinsurance-eligible recipients after December 31, 2016, except
35 to require adjustments relating to any final reconciliation of
36 collections and payments. The transitional reinsurance program
37 shall terminate on January 1, 2018.

38 (c) The director may adopt regulations in accordance with the
39 Administrative Procedure Act (Chapter 3.5 (commencing with
40 Section 11340) of Part 1 of Division 3 of Title 2 of the Government

Code) to implement this article. The department shall consult with the Insurance Commissioner in adopting necessary regulations. For purposes of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including Section 11349.6 of the Government Code, the adoption or amendment of the regulations required to be adopted pursuant to this article is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare.

1366.15. This article shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 2. Chapter 8.3 (commencing with Section 10760) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 8.3. REINSURANCE

10760. For purposes of this chapter, the following terms have the following meanings:

(a) “Applicable reinsurance entity” means a nonprofit entity that carries out the duties as described in Section 10760.5.

(b) “Attachment point” means the threshold dollar amount of costs incurred by a contributing entity for payment of ~~essential~~ health benefits; provided to an ~~enrolled~~ individual, after which threshold the costs for ~~covered essential~~ health benefits are eligible for reinsurance payments.

(c) “Benefit year” means a calendar year for which a health plan provides coverage for health benefits.

(d) “California-specific reinsurance benefit and payment parameters” means any notice issued by the commissioner describing procedures for collecting funds from contributing entities and making payments to reinsurance-eligible recipients.

(e) “Coinsurance rate” means the rate at which the applicable reinsurance entity will reimburse the reinsurance-eligible recipient for costs incurred to cover essential health benefits, upon reaching the attachment point and before reaching the reinsurance rate. Coinsurance rate may be further defined by any federal or California-specific benefits and payment parameters or regulation.

(f) “Contributing entity” means the following: ~~an entity insurer licensed as a health care service plan by the commissioner; or in the case of a self-insured group health plan covering residents of California, the third-party administrator of the group health plan~~ *to offer individual or group disability coverage providing hospital, medical, or surgical benefits within the meaning of subdivision (b) of Section 106; however, no contributing entity shall have to make contributions with respect to any insurance coverage that consists solely of excepted benefits, as defined in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91(c)).*

(g) “Covered individual claim” means a properly documented claim submitted by a reinsurance-eligible recipient for a reinsurance payment from the transitional reinsurance program.

(h) “Federal reinsurance benefits and payment parameters” means a notice issued by the Secretary of the United States Department of Health and Human Services describing procedures for collecting funds from contributing entities and making payments to eligible reinsurance recipients.

(i) “Grandfathered health plan” shall have the meaning set forth in Section 1251 of the PPACA.

(j) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(k) “Reinsurance cap” means the threshold dollar amount for costs incurred by a reinsurance-eligible recipient for payment of California essential health benefits for an enrolled individual, after which threshold the costs for covered essential benefits are no longer eligible for reinsurance payments. “Reinsurance cap” may be further defined by any federal or California-specific benefits and payment parameters or regulation.

(l) “Reinsurance contribution payment” means the required payment by any contributing entity to the applicable reinsurance entity, as further defined by regulation.

(m) “Reinsurance contribution year” means the 12-month period for purposes of assessing contribution payments from contributing entities, as further defined by regulation.

(n) “Reinsurance-eligible recipient” means, for purposes of the transitional reinsurance program, the issuer of any health plan *or*

1 *health insurance coverage* offered in the California individual
2 market that is not a grandfathered plan.

3 (o) “State high-risk pool” means health insurance programs for
4 Californians unable to obtain coverage in the individual health
5 insurance market because of their preexisting conditions. State
6 high-risk pool specifically refers to either or both the California
7 Pre-Existing Condition Insurance Plan (PCIP) and the Managed
8 Risk Medical Insurance Program (MRMIP) both operated by the
9 Managed Risk Medical Insurance Board.

10 (p) “Third-party administrator” means the claims-processing
11 entity for a self-insurer. In the case of a self-insurer that processes
12 its own claims, the self-insurer itself will be considered the
13 third-party administrator for the purpose of the transitional
14 reinsurance program.

15 10760.5. There shall be established a California Transitional
16 Reinsurance Program, in which contributing entities are required
17 to make payments to the applicable reinsurance entity, and
18 reinsurance-eligible recipients will receive reinsurance payments
19 for covered individual claims. Based upon a competitive bidding
20 process, the Insurance Commissioner shall select the applicable
21 reinsurance entity.

22 10761. ~~The commissioner~~ *Insurance Commissioner* and the
23 Director of Managed Health Care may jointly modify the federal
24 reinsurance benefits and payment parameters by issuing a
25 California-specific notice of benefits and payment parameters by
26 March ~~15~~ 1 of the year prior to the benefit year.

27 The notice shall contain at least both of the following:

28 (a) The data requirements and data collection frequency for
29 reinsurance-eligible recipients.

30 (b) The reinsurance attachment point, reinsurance cap, and
31 coinsurance rate, if different from the corresponding parameters
32 specified in the federal notice of benefit and payment parameters.

33 The commissioner’s notice shall not be subject to the
34 Administrative Procedure Act (Chapter 3.5 (commencing with
35 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
36 Code).

37 10761.5. The applicable reinsurance entity selected pursuant
38 to the procedures in Section 10760.5 shall have all of the following
39 duties:

1 (a) Collect reinsurance contributions from contributing entities
2 *and from the United States Department of Health and Human*
3 *Services on behalf of self-insured group plans.*

4 (b) Remit a portion of payments collected from contributing
5 entities to the United States Treasury as further defined by the
6 PPACA.

7 (c) Receive and maintain required claims data on all covered
8 individual claims submitted by reinsurance-eligible recipients.

9 (d) Accept and validate requests for reinsurance payments from
10 reinsurance-eligible recipients.

11 (e) Remit reinsurance payments to reinsurance-eligible
12 recipients.

13 (f) Reconcile and verify reinsurance contributions and payments
14 and resolve any discrepancy with any contributing entity or
15 reinsurance-eligible recipient.

16 (g) Report to the commissioner any dispute it is unable to resolve
17 with a contributing entity or reinsurance-eligible recipient.

18 (h) Maintain a complete accounting of collections from
19 contributing entities, payments to reinsurance-eligible recipients
20 and its own administrative expenses, and make timely reports of
21 the accounting to the commissioner and the Director of the
22 Department of Managed Health Care in a format and on a schedule
23 to be established by regulation.

24 (i) Coordinate reinsurance program with state high-risk pools
25 to the extent necessary as may be required by state or federal law.

26 (j) Any other duties as further defined by the PPACA, state
27 regulations, or any California-specific reinsurance and benefit
28 payment parameters.

29 10761.7. Records relating to claims data, reinsurance
30 contributions and payments, remittances to the United States
31 Treasury, and those pertaining to the administrative expenses of
32 the applicable reinsurance entity shall be maintained by the
33 applicable reinsurance entity for a period of 10 years following
34 the termination of the last applicable benefit year of the transitional
35 reinsurance program, as further defined by the PPACA or state
36 regulations. Those records shall be available to the Commissioner
37 and the Director of the Department of Managed Health Care for
38 inspection. The applicable reinsurance entity shall adhere at all
39 times to the confidentiality requirements in the maintenance of
40 those records as established in the federal Health Insurance

1 Portability and Accountability Act of 1996 (HIPAA) and the
2 Confidentiality of Medical Information Act (Part 2.6 (commencing
3 with Section 56) of Division 1 of the Civil Code).

4 10762. (a) A contributing entity that is licensed by the
5 commissioner shall be required to do all of the following:

6 (1) Make payments to the applicable reinsurance entity
7 according to the procedures established by the PPACA or state
8 regulations.

9 (2) Comply with all reasonable requests of the applicable
10 reinsurance entity or the commissioner for appropriate
11 documentation to establish earned premium for the reinsurance
12 contribution period.

13 (3) Comply with any additional requirements as established by
14 state or federal regulations.

15 (b) A reinsurance-eligible recipient that is licensed by the
16 commissioner shall do all of the following:

17 (1) Submit documentation on covered individual claims to the
18 applicable reinsurance entity in a format as established by any
19 federal benefit or payment parameters or any California-specific
20 benefit and payments parameters.

21 (2) Remit to the applicable reinsurance entity any payments of
22 reinsurance benefits deemed to be overpayments following an
23 audit or reconciliation of collections and payments.

24 (3) Comply with any additional requirements as established by
25 the PPACA, state regulations, or any California-specific
26 reinsurance benefit and payment parameters.

27 10763. The commissioner may issue orders to a contributing
28 entity that is a health insurer regulated by this code whenever the
29 commissioner determines that it is reasonably necessary to ensure
30 compliance with Section 10762. A health insurer to which an order
31 pursuant to this section is issued may, within 15 days of receipt of
32 that order, request a hearing at which the licensee may challenge
33 the order.

34 10764. (a) This chapter shall be effective on January 1, 2013,
35 for purposes of selecting an applicable reinsurance entity and
36 adopting regulations, including emergency regulations to
37 implement the transitional reinsurance program; however, no
38 contributing entity shall be required to remit any payment to the
39 applicable reinsurance entity before October 1, 2013, and no

1 payment to a reinsurance-eligible recipient shall occur before
2 January 1, 2014.

3 (b) The applicable reinsurance entity shall cease requiring
4 collections from contributing entities and making payments to
5 reinsurance-eligible recipients after December 31, 2016, except
6 to require adjustments relating to any final reconciliation of
7 collections, and payments. The transitional reinsurance program
8 shall fully terminate on January 1, 2018.

9 (c) The commissioner may adopt regulations in accordance with
10 the Administrative Procedure Act (Chapter 3.5 (commencing with
11 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
12 Code) to implement this chapter. The commissioner shall consult
13 with the Department of Managed Health Care in adopting necessary
14 regulations. For purposes of Chapter 3.5 (commencing with Section
15 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
16 including Section 11349.6 of the Government Code, the adoption
17 or amendment of the regulations required to be adopted pursuant
18 to this chapter is an emergency and shall be considered by the
19 Office of Administrative Law as necessary for the immediate
20 preservation of the public peace, health and safety, and general
21 welfare.

22 10765. This chapter shall remain in effect only until January
23 1, 2018, and as of that date is repealed, unless a later enacted
24 statute, that is enacted before January 1, 2018, deletes or extends
25 that date.

26 SEC. 3. No reimbursement is required by this act pursuant to
27 Section 6 of Article XIII B of the California Constitution because
28 the only costs that may be incurred by a local agency or school
29 district will be incurred because this act creates a new crime or
30 infraction, eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section 17556 of
32 the Government Code, or changes the definition of a crime within
33 the meaning of Section 6 of Article XIII B of the California
34 Constitution.